NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

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EDITORIAL

THE STANDARDIZATION OF HOSPITALS.

In a recent one-night stand at New Orleans representatives of the American College of Surgeons presented the importance of improvement in hospital conditions, and most idealistically submitted the general manner of accomplishing such improvement.

There are nearly seven thousand hospitals of all sorts in the United States, from the twenty-five-bed semi-private sanitarium to the great institutions like the Cook County Hospital in Chicago, Bellevue Hospital in New York, the Massachusetts General in Boston and our own Charity Hospital in New Orleans.

To be effective, reform must be general, and the mere academic appeal is not going to bear fruit.

The College of Surgeons is well intended, and their intentions are further encouraged by a fair bank account derived from the various surgeons in membership, with a promise of more from philanthropic sources. But even money will not make reform, without commensurate, enforced regulation. No appeal from any single body is going to accomplish the desired results. Nearly all hospitals are now conducted as their administrators will, and it is yet rare to have the medical and surgical staffs sufficiently in authority to even direct the administration, let alone to control any part of it. The intern has still a quasi-orderly position, with perhaps a prospect of rising above it, and there is not yet coördination in most places.

The American Medical Association has issued one list of hospitals, with an apology for the meager information contained. After a few years, if they go it alone, the College of Surgeons may furnish another list, with or without the apology.

The time has come for the combination of all interests concerned—first to study hospitals; and then to develop a basis for a standard; after that, some classifying may be done with a view to standardization. Just now there are problems in medical education in connection with internships, and the hospitals themselves are concerned, because of the increasing hospital need for interns and the decreasing number of medical graduates available for such positions. Hospitals under the jurisdiction of the State directly, as well as endowed or sectarian hospitals, must meet this problem.

It will be wise to bring the authorities of hospitals, medical colleges, the nurses, the interns, as well as the bodies of physicains represented by the A. M. A. and the College of Surgeons, into some organized and systematic working force to fulfil the end of studying hospitals. For it is certain that no one of these groups of individuals or institutions will submit to a dictum from any self-constituted arbiter of standards.

The public, too, is interested somewhat. When all is said, the public is perhaps the most interested, and when the final standardization of hospitals comes about, the improved history-taking, professional technic, nursing codes, intern regulations and privileges will all make for a better-satisfied public—if these reforms finally bring a better service to the patient, for whom the institution is, after all, conducted.

RETURN OF THE TULANE UNIT (BASE HOSPITAL 24).

The Tulane Base Hospital Unit, known as Base Hospital No. 24, left New Orleans in September of 1917, the first complete hospital unit to be organized in the South. It was a true university unit, as its personnel in the medical and surgical staffs was made up wholly from the faculty and from the alumni of the Tulane School of Medicine. Its nurses represented the best of the New Orleans profession and the non-commissioned personnel was almost wholly of New Orleans and Louisiana origin.

After several months of postponement the unit was finally located and put to work at Limoges, in France.

The director of the unit, Dr. John B. Elliott, Jr., and the head of the surgical staff, Dr. Urban Maes, were separated from the unit, for more advanced service. These two, as lieutenant-colonels, were placed as consultants, practically in charge of their army sectors, as medical and surgical clinic consultants, respectively. Dr. J. D. Weis early was detailed to be medical liaison officer at Paris.

More than half of the original unit was detached at one or another occasion. Captains Fenner, Lemann and Lanford were each put on important detail, either in charge of smaller or larger units or where emergency called them.

The work of the unit has been a credit to Tulane University, to the medical school and to the city and State which it represented, and if no great welcome greets the unit upon its official return it will not be because the unit has not deserved it.

Drs. Elliott, Maes, Halsey and Lemann are back. Of the others, some are in the United States and the others are either on the way or soon will be.

The JOURNAL bespeaks the privilege of saying a word of appreciation to those here and to those coming, and to add that they are welcome home and we are proud to share their glory in work well done.

MEETING OF THE LOUISIANA STATE MEDICAL SOCIETY.

With conditions a little nearer normal this year, we should have a very good meeting in Shreveport on April 8, 9 and 10. We urge all members to make an earnest effort to attend and to contribute their share towards the success which we *must* obtain for this session.

Each can coöperate in his way and to the extent of his possibilities, and he will profit in like manner.

We would gladly have published more information regarding the meeting, but the appended letter, received in answer to our request for data, is all we have been able to obtain, though we have tried from all sources to secure what we felt would interest the members.

Fortunately, Dr. Abramson's letter covers the main points, hence we publish it in full:

SHREVEPORT, March 15, 1919.

Editors NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

DEAR DOCTORS—I have not written you heretofore concerning the coming meeting of the State Society because I thought all this information was furnished from the office of the Secretary.

Arrangements for the meeting are well in hand and we hope to entertain the Society in a befitting manner. Our committee on transportation has labored for several months on the problem of securing special rates, but, so far, has been unable to obtain any concession in that particular.

The noonday luncheon on Tuesday will be tendered by the North Louisiana Sanitarium; on Wednesday by the Schumpert Sanitarium, and on Thursday by the Highland Sanitarium.

After adjournment of the meeting on Wednesday afternoon members of the Society will be taken in automobiles to view the glass factory and oil fields, and if conditions are favorable we hope to show them a real "wild well." Upon return from this trip an informal smoker will be given at the Hotel Youree.

On the last evening we shall have the usual annual meeting, when the President will read his annual message and the audience will be addressed by other prominent speakers.

I desire especially that you will request that the members will make their hotel reservations early. Address Dr. Frank Walke, chairman hotel committee, or Mr. Jennings, manager Hotel Youree. We are making every effort to see that everybody is properly accommodated, but we would request that the reservations be made at once.

Thanking you for your interest in this matter, I am, very truly yours, (Signed) LOUIS ABRAMSON,

Chairman, Committee Arrangements.

ORIGINAL ARTICLES

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

THE LABORATORY AS AN AID IN THE DIAGNOSIS OF THE PNEUMOCOCCAL COMPLICATIONS OF INFLUENZA.*

By FOSTER M. JOHNS, M. D.,
Assistant Professor, Laboratory of Clinical Medicine, Tulane University of Louisiana, New Orleans.

As we reflect upon the enormous mortality figures produced by the past epidemic of influenza, and then realize that, in the light of all of the post-mortem evidence now beginning to be available that a very large part of these deaths were directly due to a complicating pneumonia, the full significance of the correct diagnosis of the rapid sequence of pathologic changes in the course of the individual case of influenza may be realized.

An idea of the relative importance of the complicating pneumonias is admirably shown in an article by W. V. Brem in the *Journal of the A. M. A.* for December 28, 1918, in which, in a series of some 3,000 cases, pneumonia was diagnosed with certainty in 408 cases—an incidence of 13.6 per cent and with a mortality of 36 per cent, making the total mortality for the epidemic 5 per cent. Naturally, these figures are higher for army cantonments than we have in civil practice, but the interesting point is that in the post-mortems on all of the cases for the epidemic only two were found to have succumbed with a purely influenzal form of broncho-pneumonia.

During the epidemic, other complications than a secondary pneumonia were remarkably rare. It is noteworthy, however, that practically all observers, in their writings of recent date, hold that the epidemic infection now prevalent is being followed by increasing numbers of such pneumococcal involvements as septicemia, empyema, sinus and mastoid infections, abdominal and pelvic abscesses, cholecystitis, etc., following the comparatively mild lobular type of pneumonia.

While the laboratory findings in both Spanish influenza and its

*Read before the Orleans Parish Medical Society, January 27, 1919. [Received for publication February 11, 1919.—Eds.]

complications are purely confirmatory in character to the clinical diagnosis, and are in no way specific in the sense of the Widal reaction for typhoid, or the finding of the malaria plasmodia in malaria, still, when properly interpreted, the evidence shown in the blood, urine and sputum will not only be the addition of positive evidence as to the correctness of diagnosis of a complication, but in a negative way tend to prevent the occasional error of diagnosis so prevalent in epidemic and near-epidemic times.

Some of the more constant laboratory findings, such as the blood count, have been so altered by the combination, frequently, of such diseases as influenza and pneumonia, in both of which the blood counts in uncomplicated cases are so diametrically opposite that a good deal of confusion has arisen in interpreting the laboratory findings, and it is for this reason that I have selected the present subject for discussion.

The Blood.—Whatever may be the etiologic factor in the production of Spanish influenza, as we now see the disease, it is most certainly characterized by a toxemia that exerts a more specific depressant action on the production of leucocytes than we are usually familiar with. This results in uncomplicated influenza in an absolute leucopenia so characteristic of the disease.

This depressant action on leucocyte production so modifies the blood count, both total and differential, that a rapidly following pneumonia of either lobar or lobular types, and certainly due to the pneumococcus, will only increase the count several thousand cells. These leucocyte determinations show such low variations as from 6 to 8,000 in the average influenza to 10 to 12,000 with the development of the pneumonia. This difference is slightly accentuated in the differential counts, the usual 40 to 60 per cent of neutrophiles running up to 80 to as high as 95 per cent.

Pneumonias developing late, or after the influenzal process was on the wane, run more true to form and showing from 15,000 on up, with a corresponding increase in the percentage of neutrophiles and the diminution of the eosinophiles.

While these pictures are only too often the source of little positive information from a diagnostic standpoint, from the prognostic standpoint they have proven of inestimable advantage. Following the onset of the pneumonia a stationary or falling leucocytosis came very near always indicating an unfavorable termination.

A sudden increase of leucocytes marked practically all of the

extensions of the pneumonic process to the pleura, mastoid or cerebral meninges. These latter complications were practically all following the pneumonia and were removed from the inciting influenza by two or more weeks.

We have made any number of blood cultures which have proven invariably negative, these tallying with the experiences of the army laboratories, where routine blood cultures are made in all fever cases. This is rather surprising, as the usual run of pneumonia cases gave in past years a rather high per cent of positive findings.

The Urine.—Influenzal patients have almost all shown the effect of the toxemia on the kidneys by the presence of a variable quantity of albumin accompanied by hyalin casts, but the rather sudden appearance of considerable quantities of albumin, with numerous hyalin and epithelial cell casts, was most characteristic of the onset of consolidation. Enormous numbers of granular casts soon made their appearance, and, in many cases, blood.

The Sputum.—The pneumonia following influenza has almost always been lobular in character, the type of organism seemingly being due to the variety of pneumococci, streptococci, staphylococci or micrococci that predominated in the respiratory passages of the individual when becoming ill. This renders the diagnosis of pneumonia of this type rather difficult of diagnosis to the microscope. However, lung sputum collected early, washed free of the ordinary contamination and appropriately stained, gives a wealth of information as to the type of infection present in the lung itself. This, coupled with the clinical findings alone, gives an almost certain diagnosis.

Where from ten to twenty cubic centimeters of lung sputum can be collected, the rapid direct-sputum typing of Krumweide renders a certain specific diagnosis practicable in the majority of cases. This test depends upon the extraction of an antigen from the pneumococci in the sputum itself, and this extract is then precipitated by the various I, II, II*a* and III type sera prepared by immunizing rabbits with known strains of pneumococci. Reaction with this test is certain proof of the presence of a pneumonia from the number of pneumococci necessarily present in a given sputum and of a fixed type. The drawback comes in the large number of type IV infections seen in broncho-pneumonia, and against which a type serum is not practicable, owing to the large number of strains comprising the group.

While it is certain that the typing of pneumonia sputum is not as valuable in post-influenzal pneumonias as in ordinary lobar pneumonia, it is extremely valuable as a prognostic agent, type IV being much less severe than either I, II or III. I wish to thank Dr. Mattes for checking type IV by Avery method and the Rockefeller Institute for the type IV agglutins.

Pleural and Spinal Fluids.—The direct microscopical examination in both pleurisy with effusion and pneumococcic meningitis is typical and diagnostic. In the case of pleural exudates the question of paramount importance is one of operation for drainage or not. Many of the small localized and definitely infected pleurisies that I have studied in this epidemic have shown a tendency toward autosterilization and absorption following the withdrawal of small quantities for exploratory purposes. Comparative cultures from these repeated aspirations have shown the need for drainage in several instances, and *vice versa.*

Discussion of Dr. Johns' Paper.

Dr. C. C. Bass: In making observations upon any phase of the disease under discussion we must remember that during the prevalence of any disease in epidemic or pandemic form there are many instances of erroneous diagnosis. This is especially true in the case of mild diseases in which there are no infallible, clear-cut diagnostic signs or symptoms, such as the so-called "influenza" is. From the standpoint of the subject of Dr. Johns' paper, it would make no difference if cases of "influenza" are not diagnosed, but calling other diseases "influenza" would lead to the improper application of observations.

Barring rare exceptions, there is definite rise in the leucocyte count whenever pneumonia supervenes upon "influenza," as Dr. Johns has indicated in his paper. The rise is not as great as in pneumonia not complicated by "influenza," and in rare instances there may be no rise. The average of a large number of cases of pneumonia following influenza reported in the last **Journal of the A. M. A.** was about 15,000 or 16,000. The average of pneumonia, not preceded by "influenza," would fall between 20,000 and 30,000.

The greatest information from the total leucocytes count in the diagnosis of pneumonia following influenza is obtained in cases where counts have been made before the pneumonia set in. A sudden, though moderate, rise from the previous known low count is more valuable in indicating pneumococcus invasion than a higher count might be when the previous range was not known.

The differential count showing the presence of the "septic factor," with the characteristic great decrease or absence of eosinophiles, is also valuable, because, regardless of the absence of leucocytosis or even in the presence of a leucopenia, the "septic factor" is always present in pneumonia due to pneumococcus.

Lieutenant Commander R. B. H. Gradwohl, U. S. Naval Hospital, New

Orleans: I wish to thank the officers and members of this Society for their courtesy in permitting me to be present this evening and to have the privileges of the floor. I have but little to add to what has already been said on the subject of this disease. There are one or two points, however, that might well be alluded to. In first order I wish to state that I am one of those who believe that neither the causative factor nor the manner of spread of this disease has as yet been definitely established. The relatively small number of workers who have claimed to have found and isolated the Pfeiffer bacillus speaks against this organism being the microbic cause of what, for want of a better name, we have nicknamed the "flu." I want also to voice my doubts as to the exactitude of identification of the Pfeiffer bacillus by some of the reporters of this work. It is commonly the practice to call a short rod found in the sputum of these cases the Pfeiffer bacillus and to let it go at that. Cultural characteristics and biological behavior are not always sought for. Granting, however, that the Pfeiffer bacillus actually has been isolated in some of these cases, may it not be explained on the basis that there were some cases of real la grippe mixed up with this new disease? We ought to go slow, therefore, in assuming that this is really influenza and that the Pfeiffer organism is the offending organism.

Might I not at this point call your attention to the rather remarkable set of experiments recently conducted by one of the officers of our corps at Boston? These experiments have recently been noted in one of our confidential bulletins and possibly are unknown to you. They will soon be issued in the regular channels of medical literature. Two sets of experiments were carried out jointly by Lieutenant Commander M. J. Rosenau, M. C., U. S. N. R. F., and Lieutenant W. J. Keegan, M. C., U. S. N. R. F., and by Surgeon Joseph Goldberger and Assistant Surgeon G. C. Lake, United States Public Health Service, at the United States Quarantine Station, Gallups Island, Boston, Mass. The subjects are sixty-eight volunteers from the Navy Detention Camp there. The experiments consisted of inoculations with pure cultures of Pfeiffer bacillus and with secretions from the upper respiratory tract and with blood from cases of influenza. Cultures of the Pfeiffer bacillus were instilled into the noses of these volunteers, and none contracted the disease. Filtered and unfiltered secretions from the upper respiratory tract of typical cases of influenza actively infected were placed in contact with the respiratory mucosa by means of swabs, sprays, into the nose and throat. This was repeatedly carried out and none contracted the disease. Each volunteer was then instructed to converse with patients and then the patients coughed directly into their faces, each volunteer thus coming into contact with at least ten true cases of influenza. None developed influenza. The same set of experiments were carried out in San Francisco by Surgeon G. W. McCoy, of the United States Public Health Service, and by Lieutenant De Wayne Richey, of the United States Navy; none contracted the disease. I cannot refrain from alluding to the fact that these volunteers displayed a very fine spirit of courageous sacrifice in thus submitting to an experimental investigation for the good of humanity, with a full knowledge of the fact that they were risking their lives.

So far as the pathology and treatment of the cases at the United States Naval Hospital at Algiers is concerned, I wish to state that we have seen the prominent feature at autopsy there of pulmonary destruction by the ravages of this disease. This destructive tendency is, in the main, a purulent one, with lung abscesses and pus collections in the

pleural sac. The same widespread and disconcerting broncho-pneumonias have been seen there as elsewhere.

Treatment: One speaker has alluded to the practice of blood-letting at our hospital; I must frankly confess that I have seen no benefit at all from this practice; nor have we had any appreciable success with the use of vaccines.

One point in conclusion: The word "acidosis" has been used by some of the speakers here in explaining the toxemic or unusually severe symptomatology of this disease. Without decrying for one moment the good results which they state they obtained in the treatment of these symptoms by means of the intravenous use of solutions of glucose, I would suggest that some direct tests for acidosis ought to be applied before we can properly call this state one of acidosis. It may be acidosis, but, in the absence of the use of the Van Slyke or the Marriott methods, we are not at all warranted in speaking of it as such.

IS ARGYROL USELESS?

By HENRY DICKSON BRUNS, M. D., New Orleans.

At the last meeting of the Louisiana State Medical Society I had the honor of reading a little paper, "On Some Minor Matters." In the course of an appreciated, complimentary discussion following the reading, Dr. T. J. Dimitry, of New Orleans, said:

"Unfortunately, he (Dr. Bruns) did not mention anything as to argyrol. I wish he had done so, * * * because I believe argyrol is to suffer the same condemnation we have given to boracic acid. It really does little good when instilled into the eye. * * * I would say that its substitutes are every bit as good, and at the best the borax is equal to the argyrol."

I replied:

"I did not say anything about argyrol, yet I must disagree with Dr. Dimitry's prophecy."

Soon after its introduction, I began to experiment with argyrol, and came to believe in its value in certain diseases of the eye. Dr. Dimitry and several of our hearers were aware of this, and should I now permit our confrère's criticism to go unchallenged to the audience before whom it was made, I would seem to have changed my belief, to the disparagement, in their eyes at least, of what I think a valuable remedy. I do not wish to pontificate, as our French friends say, but to give as briefly as possible the reason for the faith that is in me—my own experience solely. That experience has taught me that argyrol, like all useful agents, is valuable only when employed with a full appreciation of its limitations—limitations, first, as to the strength; second, the intervals,

and third, as to the duration of its application. A strength of 2 or 2½ percent—ten or fifteen grains to the ounce at most—possesses all the valuable properties of the drug and reduces to a minimum all unpleasant or harmful effects. Such a solution is unirritating, seems to be most diffusible, and great diffusibility is one of the valuable properties of argyrol, while its specific gravity is sufficient to float out of the culs-de-sac every particle of pus or mucus. The coloration it imparts to such otherwise invisible particles makes argyrol a very useful adjuvant in thoroughly cleansing the eye when alternated with a borax wash or other neutral solution. Solutions of 25 to 50 per cent in strength are, by their thickness, made less diffusible; they seem to form with the secretions uncomfortable clots, and they are irritating; so irritating that after a few instillations it is hard, or even impossible, to persuade the patient to continue their use.

The intervals at which the solution is instilled must be short if we are to achieve the results for which we hope. Instillations should be made every hour; in the severest affections every fifteen minutes, and in the mildest at least every two or three hours. It is, probably, the use of argyrol in solutions of too great strength and its instillation at too prolonged intervals that has caused the greatest number of disappointments in its use and has led many to cast it aside.

The use of argyrol must never be too long-continued. Probably two weeks is the utmost length of time it can be used with benefit. After that, even the weaker solutions begin to irritate the conjunctiva. We must not forget that argyrol is no astringent. By undue persistence in its use we can produce one of the very mischiefs—irritation of the conjunctiva—that we are seeking to subdue. Moreover, as every one now knows, only fresh solutions made from fresh material can be used, even in the weaker solutions, without producing redness, smarting and watering of the eyes.

These conditions being observed, I have used, and continue to use, argyrol with undisappointed expectation of benefit in:

Cleansing the conjunctival sac, especially before all operations.

Cases of beginning epiphora without obvious cause, instilling it from four to six times daily, and in almost all cases of epiphora for testing the openness of the lachrymal passages.

Simple corneal ulcers, erosions, excoriations; especially the marginal ulcers of the old, where a non-irritating application is often indicated.

Mild cases of conjunctivitis, alternated with a borax-wash.

Cases of Koch-Weeks bacillus conjunctivitis. If, as first suggested to me by my colleague, Dr. E. A. Robin, the instillation of a 10 or 15 per cent solution of argyrol is alternated every hour or two with a solution of zinc sulphate of half a grain, or a grain, to the ounce, depending on the severity of the case, the action seems specific. When the instillations are properly made there is always decided improvement in twenty-four hours. Indeed, this plan of treatment is effective in all types of acute conjunctivitis accompanied by profuse secretion, not gonorrheal. That the zinc sulphate is not the only active agent in every instance, as one might assume, is illustrated by the following case:

R. N., a white boy of eleven years, having a severe acute conjunctivitis, with abundant discharge, said to be in the third day of the disease, presented himself in the clinic on August 22, 1918. The argyrol-zinc treatment was ordered, the alternations hourly. A culture from the conjunctival discharge was reported to contain streptococci and micrococcus catarrhalis. On August 28 he returned practically well. Questioning showed that, through some misunderstanding, the mother had never obtained the zinc sulphate solution; argyrol alone had been used every hour.

Cases of ophthalmia neonatorum: If instilled every fifteen, thirty or sixty minutes, the 10 or 15 per cent solution of argyrol is an efficient remedy. Remembering that argyrol is without astringent action, after all swelling and pus have disappeared for a day or two, we must, in the great majority of cases, begin the application of weak silver nitrate solution to the everted lids, continuing until the conjunctiva has become normal. This is the established treatment in our clinic at the Eye, Ear, Nose and Throat Hospital, and the records, so far as I know, show no case either of an eye having been lost which was not already destroyed, or of a cornea having become appreciably scarred which was not already invaded at the time the child was first presented for treatment. There was certainly one exception. In the case of an obstinate, obdurate, stupid mother, her infant lost an eye because, in spite of argument, persuasion and threat, we could not make her care for it even tolerably. It is only fair to say, however, that a majority of these infants are negroes or of negro blood. I believe, and Dr. Chas. W. Kollock, of Charleston, S. C., also thinks that this race enjoys a relative immunity to infections of the conjunctiva with the gonococcus. There is a greater tendency to recovery and less liability to corneal ulceration. It is certainly amazing to observe the swollen, distended lids, the corneæ immersed in pus, and to be

told by the mothers of these babies that the conditions have been present for a week or two, or more, and then be unable to detect the slightest invasion of the corneæ. I do not mean to imply that the white babies do not do as well; they do, but they are usually brought for treatment much more promptly than the negro infants. Nearly all, too, white and black, are breast-fed.

Nor can it be said of all these cases that the argyrol is useless; that in the natural course of the disease swelling and pus subside and disappear and that the silver nitrate applications effectually put an end to the disease.

Only a short time ago a white infant one month old was brought to me to be discharged from the clinic, cured. The mother said it had been presented for treatment on the fifth day of the disease (not ophthalmia neonatorum strictly). Smears of the pus showed gonococci. Fifteen per cent argyrol solution had been ordered instilled every fifteen minutes during the day and as often as possible during the night, on August 5. On August 7 this was reduced to every half hour. August 8, decided improvement was noted. On August 21, the sixteenth day of treatment, the child was discharged perfectly well, nothing but the argyrol solution having been used. I did not see this case when it entered the clinic, but the testimony of the staff was unanimous that its appearance had been unusually threatening, the swelling great and the purulent discharge profuse.

I wish to deal here, as far as possible, with what seem to be facts rather than with opinions. As in mathematics the greater contains the less, so sometimes in therapeutics. One convinced of the efficacy of argyrol in gonorrheal ophthalmia might be readier to admit the possibility of its value in other acute conjunctival diseases. I have, therefore, reviewed all the histories of such cases treated at our clinic during the years 1914, 1915, 1916, 1917 and 1918, in which gonococci were found in the smears by our pathologist. There are records of fifty-nine cases. Of these, twenty-five never returned after the first or second visit, or other plans of treatment were pursued. In thirty-four cases, therefore, nothing but instillations of 10 or 15 per cent solutions of argyrol were instilled until swelling had subsided and the discharge had virtually disappeared. After that, in the majority, solutions of silver nitrate were applied to the everted lids until the conjunctiva seemed normal. The instructions, iterated and reiterated, were to drop the solution into the eyes every fifteen minutes, day and night, the

patient recumbent and the lower lid gently drawn down with the finger on the *cheek*.. By no means was any attempt to cleanse the lids to be made. The excess of argyrol and pus was to be wiped from the cheek with moist cotton pledgets or gauze. The argyrol solution was to be instilled into the unaffected eye half as often as into the diseased one—every other time. At each daily visit the surgeon cleansed the lids, manipulating them as little as possible, with a warm borax-boracic-camphor-water solution poured gently from an undine. I have arranged the cases into three groups according to age.

In the first group the eleven patients varied in age from thirteen months to fifteen years, the average being six and one-half years. Six were white, four negroes and one mulatto. Males 9, females 2. The cases were presented for treatment in from one to six days after the mothers had noticed the affection, the average time being three and one-half days.

Six (6) cases were treated with argyrol alone, of which three brought for treatment on the second, third and sixth days of the disease respectively) were discharged cured at the end of twenty-four, twenty-one and seventeen days, respectively. Two with whom treatment began on the fifth day, deserted "practically well" after nineteen and eleven days of treatment each. One, white, *aet.* twelve, in the fourth day of the disease. On the second day of treatment, pus formation seemed to have ceased; but on the fourth day a small spot on the cornea just below the pupilary area was seen to be stained with argyrol; on the seventh day the eye was practically well, but the conjunctiva of an empty socket on the other side had become infected. The case recounted on page 429, well in sixteen days under argyrol alone, should be included here.

In one case (7), white, aged thirteen months, said to be in the second day of the disease, silver nitrate solution, 1 per cent, was instilled once at the first visit, after that nothing but argyrol solution being used. At the first examination a small area of the lower quadrant of the cornea was observed to be excoriated. In forty-four days the eye was well, a small scar remaining at the site of the ulcer.

In one case (8), white, aged five years, said to be in the third day of the disease, there was extensive involvement of the cornea. Nothing but argyrol was used until the tenth day, when 1 per cent solution of silver nitrate was applied. Perforation of the cornea

took place on the fourteenth day. Practically well in thirty-seven days, with a leucoma adherens occupying the lower third of the cornea.

In three cases (9, 10, 11) silver nitrate solution was applied when swelling and pus had virtually disappeared; in one, after twenty-fourth day of treatment, the patient deserting practically well on the forty-first day; in one, after the fourth day, which was discharged cured on the twenty-eighth day, and in one on the forty-first and last day, just before being discharged.

The second group comprised ten cases, the ages running from sixteen to twenty-nine years, the average being eighteen and one-half years. All were males; two white, six negroes and two mulattoes. Six were treated with argyrol alone. One negro, *aet.* twenty, second day of disease, was discharged cured after fifty-six days of treatment. On the fifty-first day a note says: "Ulcer developed, superior quadrant of cornea. Tinct. iodin touched to same"; the next day, "Improved," and on the last day, "Yellow oxide salve." A nubecula, therefore, probably remained. Two negroes (2 and 3), second and fourth day of the disease, *aet.* sixteen and twenty, deserted on the sixth and eighth day of treatment, one "almost well," the other "very much improved; very little secretion." One (4) other negro, *aet.* twenty, in the ninth day of the disease, deserted after the sixth day of treatment, "somewhat better; less secretion." Another (5) negro, *aet.* twenty-eight, in the fifth day, deserted after six days of treatment. On the second day the note says: "Cornea cloudy." On the third day, "Much improvement. Cornea slightly infiltrated." On the sixth day, "Cornea clearing up." One (6) negro, *aet.* twenty-eight, both eyes affected for a week; the right cornea "involved"; vision reduced to finger-counting at three feet, deserted after forty-three days practically well, V., O. U., under atropin, $^{20}/_{20}$.

In four cases silver nitrate was also used. One was a white man, twenty years old, seen on the third day of the disease. The silver solution, 1 per cent, was applied once only, at his first visit. He was allowed to return to his home out of the city on the nineteenth day, practically well, with vision improved from $^{20}/_{70}$ to $^{20}/_{20}$. This was a case of medium severity, but on the sixth day there is a note: "Cornea stained slightly."

In two other cases, both mulattoes, seen on the second and on the eighth day of the disease, the silver nitrate solution was applied in one case once, and on the eighth day of the disease, when

he deserted, "much improved" In the other case it was used on the thirtieth day. On the twenty-first day a "corneal ulcer" is noted, which was touched with tincture of iodin by the assistant surgeon in charge. Six days later improvement is noted, and he was discharged cured on the ninety-fourth day, the last thirty-three days being devoted to an attempt to clear the leucoma by the use of dionin.

In the last of these cases (negro, *aet.* twenty), seen on what he said was the eighth day, both eyes were affected and "minute infiltrations" of both corneæ were noted at the first visit. R. E. V.=l. p. L. E.=fingers at eight feet. There was perforation of the right cornea on the sixth day of treatment, and of the left on the thirteenth day; in both instances near the upper margin. On the sixteenth day of treatment the discharge had ceased and the application of a 1 per cent silver nitrate solution was begun. On the twenty-first day it was noted that the perforated cornea of each eye was beginning to heal. On the seventieth day he deserted, "practically well," but with leucoma adherens O. U. and V. R. E.=$^{20}/_{100}$, L. E.=$^{20}/_{30}$.

In the third group there are twelve cases, varying in age from thirty to sixty-three years, the average being forty-eight and one-half years. Four were white, three mulattoes and five negroes.

One negress, aged thirty-three, in the second day of the disease, a mild case, was treated with 15 per cent solution of argyrol alone, instilled every hour. On the seventh day, being practically well, she deserted; V. R. E.=$^{20}/_{30}$, L.L. E.=$^{20}/_{20}$.

One (2) a fifty-year-old negress, who said her eye had "been this way" three weeks, had an open sty on the upper lid of the affected eye. Treated for eighteen days with argyrol alone, she had grown much better, when "zinc sulphate" solution (!) was substituted by the assistant surgeon in charge and continued for eleven days, when the argyrol was resumed. Discharged on the fifty-third day, with vision improved from $^{20}/_{50}$ to $^{20}/_{20}$.

3. Negro, *aet.* thirty, eye affected five days. Argyrol alone for four days; when discharge having entirely disappeared, silver solution was also used with gradually diminished frequency for thirty-four more days, when he was discharged cured with vision improved from finger-counting at two feet to $^{20}/_{50}$.

4. White man, *aet.* fifty-eight, says his eye has been affected ten days. Argyrol alone for seven days and then silver solution gradu-

ally diminished for three days, when he deserted practically well. Discharge disappeared entirely on the third day. V. from $^{20}/_{100}$ to $^{20}/_{70}$ under atropin.

5. Negro, *aet.* thirty-five, affected four days. Argyrol alone for six days and then silver nitrate for twenty-eight days more, when he is discharged cured. Discharge disappeared on the fifth day. V. from $^{20}/_{70}$ to $^{20}/_{15}$.

6. Mulatto woman, *aet.* sixty-three, eye affected ten days. Notes defective, only extending over ten days. No treatment noted other than argyrol, 15 per cent, every thirty minutes, save application of silver solution *to other eye* on the eighth day. Ulceration of cornea at the upper limbus is noted on the ninth day. History marked, "Discharged cured."

7. Negro, *aet.* forty-six; both eyes have been affected for a week, he says, and both corneæ are ulcerated. Argyrol alone used six days and then silver nitrate in addition. On this day patient squeezed out lens of L. E. On the twelfth day of treatment the right cornea was perforated. On the thirty-ninth day, smears showing the absence of gonococci, he was discharged. V. R. E.= $^{20}/_{200}$.

8. Mulatto woman, *aet.* thirty-eight, who says her "eyes have been this way eight days." On the fourth day of treatment infiltration of the right cornea is noted. On the eleventh day, there being little, if any, improvement, 1 per cent silver solution is applied to the conjunctiva of the carefully everted lower lid of R. E. It is applied in this way to each eye until the forty-sixth day, when it is applied to *both* everted lids of each eye. On the fiftieth day the corneal ulcer was touched with tincture of iodin. She was discharged cured on the eighty-eighth day, much time having been spent on the treatment of the leucoma.

9. Negro, aged thirty. Seen on fifth day of disease. R. E. cornea almost wholly destroyed. Better from the fourth day. Argyrol alone until fourteenth day. Discharged on twenty-eighth day; cornea of R. E. opaque. L. E. V. $^{20}/_{15}$.

10. White woman, *aet.* thirty. Seen on fourth day of disease. On third day of treatment a slight excoriation at the lower limbus is noted. On the fourth day, "almost well; no discharge; corneal lesion remains slight and superficial." Argyrol was used alone until the fifth day, then silver nitrate solution. Discharged cured on the twentieth day, V.=$^{20}/_{20}$.

11. White man, *aet.* thirty-one. Duration of disease uncertain, but long. R. E. cornea sloughed away. L. E. also affected and presents a traumatic cataract. On the fifth day lens and vitreous escaped from R. E. Argyrol alone until the thirty-fourth day, and then silver nitrate also. His L. E. escaped undamaged.

12. White man, *aet.* thirty-nine, in second day of disease. Both eyes affected, but a very mild case. V. R. E.=$^{20}/_{30}$; L. E.=$^{20}/_{20}$. Argyrol alone until the ninth day of treatment, then silver nitrate, one-fifth of 1 per cent. Quit cured on the twenty-seventh day.

SUMMARY.—The records of the Eye, Ear, Nose and Throat Hospital for the five years 1914-1918 show fifty-nine cases of gonorrheal ophthalmia, the diagnosis being confirmed by the microscope.

Of these fifty-nine cases, thirty-four are available for the purpose of this study; whites thirteen, negroes fifteen, mulattoes six. Males were twenty-six, females eight. The ages ran from thirteen months to sixty-three years.

Of the thirty-four, four were admitted to the hospital certainly; perhaps one or two more. The others were treated as "out-patients."

Treated with argyrol alone, fourteen cases. Of these, five were discharged cured in fourteen, nineteen, twenty, forty-one and sixty-one days; four deserted practically well after eight, twenty-two, twenty-four and fifty-six days, and five deserted improved after from five to eleven days. The cornea was found involved in three cases; it became involved during treatment in two others; in one on the fortieth day, but neither perforation nor serious leucoma resulted in any. It was noted that the discharge had disappeared on the fourth day of treatment in two, on the fifth in one, and had greatly lessened on the fifth day in one case. Both eyes were found to be affected at the first visit in two cases. (Case mentioned on page 429 included here.)

In nineteen cases silver nitrate was used in addition to argyrol in the treatment. In two cases it was used once, when the case was first seen. One discharged cured in nineteen days, and one, in which the cornea was found to be involved on the first visit, quit practically well after forty-five days.

In nine cases the silver nitrate was applied on the fourth to the eighth day of treatment. Of these, six were discharged cured in from twenty-one to thirty-nine days.

Both eyes were found affected at the first visit in one case. The

cornea was badly involved and was perforated later in one case; it became slightly involved during treatment and afterwards cleared up in one case. The three other cases deserted in from eight to ten days much improved. Disappearance of discharge noted twice on the third day, and three times on the fifth.

In eight cases the silver solution was used from the tenth to the thirty-eighth (last) day of treatment. Of these, one deserted on the forty-first day greatly improved. All the other seven were discharged cured, so far as the acute condition was concerned, in from twenty-four to one hundred days, but in four the cornea was found to be involved at the first visit and later became perforated. In one case it became ulcerated and in another perforated during treatment. In three cases both eyes were affected when the patient was first seen.

Thus there were in all nine cases in which the cornea was found to be involved at the first visit, and of these five were perforated. During treatment the cornea became involved five times, and in one was perforated; that is to say involved, in spite of treatment, in about 15 per cent of the cases and perforated in about 3 per cent.

But perhaps the most striking fact is that, although no attempt was made to protect the healthy fellow-eye, save by dropping into it the argyrol solution half as often as it was dropped into the diseased eye, no unaffected eye ever became infected during the course of treatment, with one exception. This exception very emphatically "proved the rule." It occurred in the case of a white lad of twelve years, whose L. E. had been enucleated several years ago. The assistant surgeon in charge of the case, not dreaming that the empty socket might be in danger, did not drop the argyrol solution into it, and infection took place.

Used in the manner described, I have seen but two cases of staining of the cornea by argyrol. In both the area was minute. I presume that, though small, the ulceration was deep.

With the various substitutes for argyrol I have had little or no experience.

PRACTICAL CONGENITAL SYPHILIS.

By CHARLES JAMES BLOOM, B. Sc., M. D., New Orleans.

Undoubtedly the choice of the above subject bears criticism from two viewpoints—namely:

(1) The use of the word "practical."
(2) The commonplace subject "syphilis."

The average reader of medical journals becomes very much annoyed by persistently reviewing articles pertaining to the subject of syphilis, remarking *ad libitum,* "It is as old as the hills"; "they cannot tell me much about syphilis"; "give us something new," etc.; but gentlemen, we falter when we are placed on record as uttering such statements. Indeed, many of us overlook more than the mere reading of articles bearing on lues; we fail utterly to diagnose the disease in its incipient expression; we lag sadly when attempting to study in detail this social disease which is directly responsible to all mankind for so much suffering—yes, both the infant and the adult.

Picture the infant, virtuous in its entirety, the essence of loveliness and the exemplification of happiness, born, harassed, hampered, diseased by this the lowest form of animal life. Can any one describe a more disastrous agent acting as a handicap in our race and desire for existence, actually poisoned by the fangs of this dreaded monster? If such be true, and our children are forced to suffer as a consequence from "the sins of the parents," etc., should it not be the ambition of the physician to stress every point in attempting to recognize syphilis at the time of birth, and to limit the destructive influences noted by its presence?

Syphilis is not practical—most impractical when the question of diagnosis is considered. It is true that "syphilis is syphilis," no matter where seen, but it is equally certain that climate, race, food, etc., all have their respective influences. Many of us believe the question of determining cases of congenital lues a simple procedure. In this relation we are misguided in most cases, and particularly with regard to latent symptoms; these are most difficult to interpret correctly, for more often they are wanting.

The method assumed by me places the burden of proof in the hands of the physician; the latter must prove that the infant has not syphilis.

During the past five years the author has had ample opportunity to study intricately, in the outdoor clinics of our hospitals, this vital subject. This paper has no tinge of originality; it does not tend to prove or disprove the laws of Colle and Profeta; the relative value of the different laboratory aids does not enter into this discussion, nor does the term "hereditary" bear argument. The real aim of this short narrative is to stress the more common symptoms and to ask minute coöperation in endeavoring to minimize the future evils by *diagnosing the early and recent symptoms* of congenital lues.

Be mindful of the fact that syphilis was described in the Old Testament, and as a clinical entity was first illustrated when Charles VIII (1494-1495) lay siege to Naples, and still we have a great deal to learn about its clinical picture. Our city offers a wonderful opportunity for the study of lues—geographical, social and environmental factors—and finally let the importance of this topic be ever with you, for a great number of cripples, idiots, imbeciles and the insane are directly responsible to syphilis and to the doctors.

This paper is based on fifty cases. In each case the Wassermann of the mother was positive; in four cases the father's Wassermann was also positive. A positive Wassermann was also secured in all of those cases over six years of age.

Family History: 1 miscarriage in 1 case.
2 miscarriages in 3 cases.
3 miscarriages in 2 cases.
Still-birth in 1 case.
Death in infancy in 1 case.
Total, 8 cases—16 per cent.

Age, Sex, Race: Under 12 months, 23 cases.
Under 6 years, 30 cases.
6 years to 13 years 20 cases.
Male, 26; female, 24; white, 38; negro, 12.

SYMPTOMS—OBJECTIVE.
I. EARLY OR RECENT.

CHILDREN UNDER SIX YEARS.

Case.	Age.	Eruption.	Peeling—hands and feet.	Wasting.	Snuffles.	Cry (hoarse) laryngitis	Facial expression.	Tissues.	Mucous patch.	Malformed nail.	Parrot's pseudo paralysis (catcher-dititis) periostitis, etc.	Thickened eyelids and eyebrows.	Hypertrophied a) Liver. b) Spleen. c) Glands.	Digestive disturbance.	Wig.	Alopecia.	Nephritis.	Hairy skin.	Nervous symptoms: (Restlessness) (Convulsions)	Prematurity.	Dactylitis.	Number of Symptoms.
No. 2.	5 years.				+					+		+	L. G.	+	+				+			3
7.	4 years.										+	+			+							5
9.	3 weeks	+		++	++		+								+	+			+			6
13.	3 years.	+			+				+							+			Convul.			7
14.	11 years.			++	++		+						L. G.		+	+						8
15.	4 years.	+		+	+		+								+	+						6
17.	37 days.	+	+	+	+		+							+	+	+		+				9
19.	1 month.	+		+	+		+						L. G.		+	+						7
20.	2½ month.	+		+	+++		+		+		+			+	+	+						9
21.	6 month.			+	+		+				+		L. S. G.	++++	+	+						9
22.	3 month.			+	+		+				+		L. S. G.	++++	+	+						8
24.	1 year						+				+		L. S.	+								4
27.	3 months.	+		+	+								L. G.	+		+						6
28.	4 years.			+			+				+			+								4
29.	11 days.	+			+										+		+					5
30.	5 weeks.		+		+		+				+++		L.			+						6
33.	11 months.																					0
34.	11 months.																++	+	+	+		4
37.	2 weeks.		+	+	+										++		++					5
38.	9 weeks.	+	+	+	+		+							+	+							7
39.	2 weeks.	+	+	+	+		+								+							5
40.	2 months	+		+	+		+								+							5
41.	2 months	+	+	+	+		+								+							6
43.	5 weeks.	+		+	+										+	+						5
44.	3 months	+			+		+								+							4
45.	6 weeks.		+		+																	2
46.	2½ weeks.			+										+						+		3
48.	5 weeks.				+										+							3
49.	2½ weeks.	+	+	+	+	+	+		+		+	+	L. S. G.		+	+						12
50.	3 weeks.	+			+											+						4
30		16	8	18	24	10	16	0	3	2	7	4		10	16	13	3	2	4	2	0	Average, 5+

Eruption: The eruption was seldom seen at birth, generally developing after several weeks had elapsed. The lesions noted were of the maculo-papular variety, and were seen on the extensor surfaces of the extremities, usually bilateral and symmetrical; occasionally viewed on the neck, cheeks and forehead. Sometimes scales (fine) were detected. The appearance is gradual. The scaling or peeling of the hands and feet was coincident with the eruption. A copper pigmentation often told the tale of a previous specific lesion.

Wasting and Marasmus; Digestive Disturbances: Many infants, apparently healthy at birth, without warning become emaciated; others exhibit apparently a toxic diarrhea, not traceable to indiscretion of diet or improper methods, and, despite heroic measures undertaken to assist the mother and also the child, the stool continues frequent, greenish in color, and containing a rather large amount of mucus. It is stopped when the specific treatment is given.

Snuffles: This is undoubtedly the most valuable symptom among the early manifestations. All sorts of opinions are expressed, most often adenoids and tonsils. In only two cases where the "snot" was noticeable were the conditions cases of adenoids; in the remaining cases the specific was for the etiological factor.

This symptom might simulate a mild coryza on the one hand; at the same time other cases might be so pronounced as to justify in the minds of a layman an operation, for, in this, children's breathing is most difficult.

Cry (Hoarse) Laryngitis: A cry that one should associate with an older child who is suffering from an attack of mild laryngitis, rather characteristic to one accustomed to hearing it.

Facial Expression: The greater per cent of syphilitic children all have a haggard and old expression, and infrequently, although you might not have seen the infant at birth, the picture is so impressive that the mother will voluntarily tell you, "Yes, my baby looked like an old man."

Fissures and Mucous Patches: These expressions of lues are not as common as text-books would lead you to believe. Occasionally you detect mucous patches, and only in one case did I ever note a condyloma.

Malformed Nails and Onychia: Authorities tell us that the finger nails of this disease, when they are present, are most significant. In one case the finger nails were peculiar—very hard, but

distinctly short. Onychia was observed in one case, photographed in this series.

Parrot's Pseudo Paralysis and Weakness of Muscles: Under this heading are included all the pathological expressions of the luetic bone changes. Without warning the child awakens, unable to move one or more of its extremities, generally one, or, when moved, the infant shrieks with pain. Coincident with this the muscles are so atrophied that the combination tends to convey the impression of paralysis.

Thickened Eyebrows, Eyelids, Hairy Skin: So seldom seen as not to warrant a prolonged description. When the hair is present there are spots on the arms, thigh and back that are more pronounced.

Hypertrophied Liver, Glands, Spleen: This triad is seen, but not nearly as often as described by various teachers and writers. You will generally see that you seldom have the characteristic hardened liver with the accompanying general adenopathy involving all of the superficial groups; they are hard to touch, and as a rule have a tendency to be discrete. As yet I have never seen a specific gland become necrotic.

Wig; Alopecia: Another very valuable aid. A marked amount of hair on the skull; by itself has no importance, but in conjunction with other symptoms serves as a great agent in detecting lues. Quickly following the admonition of this "wonderful head of hair" comes the grief when the greater part will "fall out." This might be the cause of a parent's visit to your office.

Nephritis: When this symptom exists indeed one has a great task before him. The swelling is so quick and so marked that if one be slow in determining the cause the patient will quickly succumb. Casts in great numbers are generally seen, with but a small quantity of albumen, the microscopical findings depending on the type of nephritis existing.

Nervous Symptoms; Prematurity and Dactylitis: These were practically wanting symptoms in this series.

Summary—Early and Recent Symptoms:

(1) Snuffles, 24 out of 30 cases.
(2) Wasting, 18 out of 30 cases.
(3) Facial expression (old), 16 out of 30 cases.
(4) Digestive disturbances (gess what), 16 out of 30 cases.
(5) Eruption, 16 out of 30 cases.

As a rule, if care is exercised in an examination, an average of five symptoms will be found.

NUMBERS AND LEGENDS OF CUTS ILLUSTRATING DR. BLOOM'S ARTICLE.

(1) Luetic nephritis.
(2) Luetic onychia.
(3) Luetic nephritis.
(4) Typical luetic infant.
(5) Luetic child (epileptic).
(6a) Profile. Goiter associated with lues.
(6b) Full face. Goiter associated with lues.
(7) Hutchinson teeth.
(8a) Profile. Goiter associated with lues.
(8b) Full face. Goiter associated with lues.

SYMPTOMS: OBJECTIVE.

II. LATENT. Children Between Six and Thirteen Years.

Case.	Age.	Sabre deformity.	Teeth.	Eyes.	Nose.	Ears.	Stigmata.	Mental backwardness.	Boils.	Café au lait.	Ataxic gait.	Luetin.	Goître.	Nervousness.	Symptoms.
No. 1.	9 years....	—	S	—	—	—	—		—	—	—	—	—	+	0
3.	10 years....	—	—	—	—	—	—	Second grade	—	—	—	—	—	—	1
4.	10 years....	—	—	—	—	—	—	Sixth grade	—	—	—	—	—	—	1
5.	10 years....	—	—	—	—	—	—		+++	—	—	—	+	—	2
6.	7 years....	—	S	—	—	—	—	Yes	+++	—	—	—	—	+	3
8.	6 years....	—	—	—	—	—	—		—	—	—	—	—	—	0
10.	8 years....	—	S	—	—	—	—		++	+	—	++	—	—	2
11.	11 years....	—	—	Interstitial keratitis	—	—	—	Fourth grade	—	—	—	++	—	—	2
12.	12 years....	—	—	—	—	—	—	Third grade	—	—	+	—	—	+	3
16.	6 years....	—	S	—	—	—	—	First grade	—	—	—	—	—	Shakes hands	2
18.	6 years....	—	S	—	—	—	—		+	—	—	—	—	—	1
23.	7 years....	—	S	—	Flat	+	—	Yes	—	—	—	+	+	++	5
25.	12 years....	—	—	—	—	—	—		—	—	—	—	—	—	0
26.	6 years....	—	—	—	—	+	—		—	—	—	—	—	+	2
31.	12 years....	—	H	—	—	—	—		—	—	—	—	—	Shakes head	1
32.	12 years....	—	H	+	—	—	—		—	+	—	—	—	—	3
35.	9 years....	—	—	—	—	+	—	Yes	+	—	—	—	—	+	4
36.	11 years....	—	—	Mitral regurgitation											1
42.	9 years....	—	—	—	—	—	—	Mute	—	—	—	—	—	—	1
47.	8 years....	—	—	Nephritis					—	—	—	—	—	—	1
20	....	0	2	2	1	3	0	9	4	2	1	2	2	8	Average, 1½ symptoms

S—Serrated (excluded)
H—Hutchinson.

Optic neuritis.

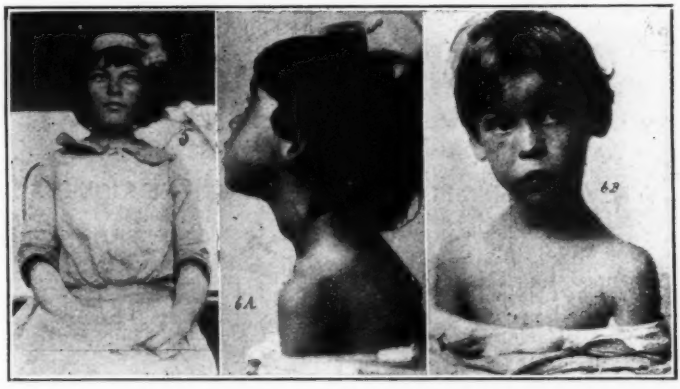
Chronic otitis media.

Coffee-ground spots.

Excluded in average of symptoms.

The triad, keratitis, chronic otitis media and Hutchinson teeth, are seldom seen.

In considering as a whole the symptoms associated with latent congenital lues of these twenty cases, there were only three that



presented positive pathognomonic symptoms. Compare the average number of symptoms of the latent group with the group under the recent symptoms, and the comparison will be as 1 to 5. This statement is emphatic; it should be the inspiration for a more con-

scientious examination for congenital lues at birth, even if there be no justification based on past history.

CONCLUSION.

(1) Use every means possible to diagnose the early manifestations of syphilis, for, if undiagnosed at birth, the latent symptoms are few, or entirely wanting.

(2) Conscientiousness in behalf of the infants will mean the prevention of idiocy, imbecility and insanity and will tend to help mankind from a moral, sociological, educational and economic standpoint.

A NEW TECHNIC FOR SUSPENSION OF THE KIDNEY.

By RAWLEY M. PENICK, M. D F A. C. S., Shreveport, La.

In presenting this technic it is scarcely necessary to review the literature further than to justify the belief that I have held, that a more satisfactory, and at the same time simple, technic is desirable in fixing the freely movable kidney.

A great deal has been written and many new procedures have been proposed lately showing that no operation now in use is generally acceptable and satisfactory to operators.

In the beginning it may be well to say that, unless a kidney produces marked symptoms, usually the group known as Dietels' crisis, its mere mobility does not justify nephropexy. It seems, however, that a kidney with excessive mobility is almost sure to give serious trouble at some time or other.

And it is well to bear in mind that in practically every case of movable kidney the abdominal walls are found very lax, demonstrating the very important part they play in supporting the normally placed organs, and the aftertreatment should take care of this condition following nephropexy.

An interesting and rather remarkable fact has been the recovery or improvement in a number of cases operated on by English surgeons of movable kidney associated with insanity. Suckling reports twenty-one cases where insanity disappeared after fixation of the kidney, and Billington reports most encouraging results obtained in the same manner.

To return to the discussion of the technic: If the capsule of the kidney or its cortex were strong enough under all conditions to hold sutures without giving away, the problem in suspension would not

exist, and the most generally employed operations in this condition at present have as a distinguishing feature the more or less ingenious placing of the sutures in the capsule or cortex, or both, that they may successfully withstand the strain while the decorticated kidney becomes adherent to the musculature of the back.

I desired to avoid using sutures in the substance of the kidney for two reasons: it is more or less injurious to the kidney and of little strength where stress is present.

This was overcome by Senn by the use of the gauze slings temporarily placed around the upper and lower poles of the kidney and later withdrawn, after adhesion of the partially decorticated kidney had taken place. As far as I am able to ascertain, Senn was the first to employ this principle. Penrose and Bayes adopted it, but used rubber tubing in the place of the gauze.

The objections to using foreign material in this work is too obvious to dwell upon, but the principle seemed to me so good and sound that I felt that the problem would be solved if I could utilize an autogenous sling, and the deep lumbar fascia immediately suggested itself as lending itself ideally for that purpose.

It is not the first time that the fascia has been used in this operation, as one operator dissected the deep fascia from the muscles in such a way as to form a pocket, but serious objection arose to this procedure. And I desire to say that if any one else has employed the fascia as I have in this operation, I have not been able to find any mention of it in the literature at my disposal.

After all, the original element in my technic is this disposition of the fascia, the remainder being simply the well-known method of stripping back the capsule and introducing sutures in each side.

It is of interest to note that Jonnesco has lately devised a similar operation, the difference being that he uses bands of the fibers of the quadratus—apparently a much more formidable operation.

The technic in detail is as follows: I use the Kelly incision, approaching the kidney through the superior lumbar trigonum, only I make the incision a little larger, if necessary. When the deep lumbar fascia is reached it is opened with a clean cut, and beginning at the lower angle of the wound a ribbon of fascia is dissected about two-thirds of an inch wide. The end is secured with a hemostat and laid aside for the present, and the operator proceeds to deliver the kidney up into the wound as usual. The perirenal fat is stripped to the hilum and the capsule incised and dissected, the sutures in-

troduced, two on each side. These sutures are caught in hemostats and laid aside while the perirenal fat is gathered by a circumferential large suture, forming a cup-shaped support under the kidney, and the ends are left long for later attachment at the lower angle of the wound in the musculature.

The ribbon of fascia is now picked up and a large chromic gut suture threaded into the end to prolong it; it is then fitted around the lower pole of the kidney, just below the hilum, and a stitch securing it to the capsule of the kidney near the front is introduced to prevent slipping. The ends of the suture, prolonging the ribbon of the fascia, are left in the hemostat while the kidney is being replaced, and the sutures of the capsule are secured in the adjacent musculature, as usual in this procedure.

When this stage is reached the kidney is placed in the position desired and the suture prolonging the ribbon of fascia threaded on a carrier or large needle and fixed in the muscles of the back, at the most convenient point, fitting snugly around the kidney and holding it securely while the denuded surface on the kidney forms adhesions.

The large sutures in the subphrenic fat securing a support under the kidney are now drawn sufficiently taut, forming a cup-shaped support. This last procedure closes the loose space under the kidney and, while it may not be necessary, it is quickly and easily done; indeed, Dr. Bartlett uses this principle alone, almost, in dealing with this type of kidney surgery. The wound is then closed in the usual way, layer by layer.

Conclusions.

1. The use of fascia seems logical, gives the greatest security under the severest post-operation strain, and prevents tilting, rotation and sagging

2. It is easily and rapidly done.

3. Good surgery demands that we employ methods that insure the greatest security, and this technic seems to give us that security.

4. It is reasonable to suppose that the fascial band eventually forms a stable ligamentous support that would hold the kidney in place in the absence of any other support.

NEWS AND COMMENT

THE ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE, participated in by the Council on Medical Education of the A. M. A., the Federation of State Medical Boards of the United States and the Association of American Medical Colleges, was held at the La Salle Hotel, Chicago, March 3 and 4, 1919. Each body furnished a most interesting and instructive program, at the close of which the annual business meetings were held.

WHISKEY TO HOSPITALS.—The Federal authorities recently delivered fifty gallons of whiskey to the King's Daughters' Hospital, of Tyler, Texas, the whiskey having been donated to the hospital by several men who were convicted of violating the Reed Prohibition Law in the Federal court there. The whiskey will be used by the hospital for medicinal purposes and will probably be sufficient to last several years.

CONGRESS AIDS CAMPAIGN AGAINST VENEREAL DISEASES.—The sum of $1,000,000 has been voted by Congress to aid the States in their present campaign against venereal diseases. Thirteen States have already taken up the movement.

JOURNAL OF ORTHOPEDIC SURGERY.—The *American Journal of Orthopedic Surgery* has dropped the "American" from its title, becoming the official publication of both the British and the American Orthopedic Associations. Editors from both organizations will serve, and so the whole English-speaking world will be reached.

ROALDES PRIZE.—The Roaldes prize of the American Laryngological Association, amounting to $200, is offered this year in general competition for the best thesis on some subject directly connected with laryngology or rhinology. Papers must be in the hands of the secretary, Dr. D. Bryson Delavan, 40 East Forty-first street, New York City, prior to June 1.

PAN-AMERICAN CHILD WELFARE CONGRESS.—Through the Uruguay Legation, the United States has been invited to send delegates to the second Pan-American Congress for the Welfare of the Child, to be held at Montevideo, May 18 to 25. The congress has been postponed several times because of the war.

RESTRICTION OF GERMAN MEDICAL PRACTICE.—Evidence of American determination to prevent fraternization between Germans

and men of the United States army of occupation was given some few months ago at Coblenz, when orders were issued forbidding American soldiers to consult German doctors.

EMERGENCY TRANSPORTATION.—The Paris Municipal Council, during the epidemic of influenza in France, appropriated 50,000 francs to defray the expense of transportation of physicians by means of auto-taxis, in order to insure immediate medical attention for the sick.

AMERICAN JOURNAL OF CARE FOR CHILDREN.—With its January issue this journal became a monthly periodical, dealing extensively with the rehabilitation of the invalided soldier. The journal is in no sense a war product, as it is now entering upon its eighth volume. The editor is Douglas C. McMurtrie, of New York.

THE AMERICAN BOARD OF OPHTHALMIC EXAMINATIONS.—The next examination of this board will be held at Wills Eye Hospital, Philadelphia, June 6 and 7, 1919. The board is composed of representatives of the American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association, and the Academy of Ophthalmology and Oto-Laryngology. Details with reference to the examination may be obtained from the secretary, Dr. Wm. S. Wilder, 122 South Michigan avenue, Chicago, Ill.

GIFTS TO HOSPITALS AND SCHOOL.—The Marquette Medical School Dispensary recently received $133,000 as an endowment by the family of Patrick Cudahy; Johns Hopkins Hospital, Baltimore, $400,000 for the erection of a building to serve as a women's clinic by an anonymous donor; and Johns Hopkins University, Baltimore, the "Tudor and Stewart Club," in memory of Revere Osler, endowed by Sir William and Lady Osler.

SERVICE FOR TRAINED SANITARIANS.—Well-organized health departments is the subject of consideration in many communities because of the threatened recurrence of influenza next year. Formerly great difficulty was experienced in obtaining men well trained in medicine, epidemiology, vital statistics, water supply, sewage disposal, and in every branch of city positions. Men are now returning to civil communities who have served in the Medical Corps of the Army and who are excellently equipped for positions as health officers, laboratorians, vital statisticians, sanitary engineers, industrial hygienists, school medical inspectors, etc. A health employ-

ment bureau at Boston has been established by the American Public Health Association to supply men for such positions. When they return from service they will register with the bureau, and when a request for help comes from the bureau they will be notified and sent to the prospective employers. This service is rendered without pay either to the employers or applicants.

Discharge of Tuberculous Soldiers.—In a hearing before the Senate Committee on Public Buildings, Dr. W. G. Stimson, of the United States Public Health Service, declared that 24,000 soldiers had been discharged from the army as tuberculous since the beginning of the war. He said that the history of the patients indicated that they would be in the hospital one-third of the time. Dr. Stimson submitted plans for adding 2,000 beds to the existing hospitals.

Quadruplets Born.—An Italian woman living in Philadelphia gave birth to four seven-pound children, two boys and two girls, on February 16, adding them to her nine living children. She had previously given birth to fourteen children, five of whom died. The two girls are blondes, while the boys are dark. The mother is forty-two years of age and she was married at fifteen.

American Medical Editors' Association.—The forthcoming meeting of this association, which will be held in Atlantic City in June, 1919, at the Marlborough-Blenheim Hotel, will be the fiftieth anniversary of this society. Every effort is being made to make its golden jubilee a memorable occasion. Arrangements for the Victory Golden Jubilee Banquet, to be held on the evening of June 10, are now being made, and the secretary-treasurer, Dr. J. MacDonald, Jr., 92 William street, New York City, would be glad to receive in advance any notification of a desire to attend.

Public Health Education Campaign.—One of the first of the peace-time activities of the Red Cross is a nation-wide campaign for public health education. As chautauqua itineraries offer unusual opportunities to reach communities most in need of health work, the Red Cross Department of Nursing is assigning between thirty and forty of its ablest nurses, who have returned from overseas, to lecture on the principal chautauqua circuits in the country. The lectures begin June 1, and in each instance will be followed by a squad of other nurses and Red Cross workers who will conduct a health exhibit and give practical demonstrations.

THE UNITED STATES CIVIL SERVICE COMMISSION announces an open competitive examination for assistant in pharmacology, for both men and women, to fill a vacancy in the Hygienic Laboratory, Public Health Service, Washington, D. C., at entrance salaries ranging from $1,500 to $2,000 a year. This examination is open to all citizens of the United States and will be held in most important cities throughout the country on April 29, 1919. For further information, applicants should apply for Form 1312, stating the title of the examination desired.

PERSONALS.—Among the Louisiana men who have returned, since our last list, from service in this country or abroad, are: Drs. I. I. Lemann, Urban Maes, J. B. Guthrie, J. B. Elliott, Russell E. Stone, J. W. A. Smith, of New Orleans; Dr. C. McVea, Baton Rouge; Dr. H. P. Doles, Blanchard; Dr. A. B. Wheelis, Marion, Dr. W. W. Smith, Shreveport; Dr. J. F. Polk, Slidell; Dr. F. R. Deans, White Castle; Dr. R. D. Martinez, Bunkie; Dr. W. N. Hankins, Derry; Dr. O. P. Daley, Lafayette; Dr. R. C. Webb, Rayne; Dr. R. L. May, Delhi; Dr. P. T. Thibodaux, Donaldsonville, and Dr. J. W. Lea, Jackson.

Dr. W. I. Wimberly has recently opened up offices at 3602 Prytania street, New Orleans.

Dr. James Joseph Ryan, 1217 Maison Blanche Building, New Orleans, announces that his practice is limited to diseases of the ear, nose and throat.

Dr. Henry Leidenheimer, who was serving as house surgeon at the Charity Hospital during the absence of Dr. Maurice Gelpi, called for service in the army, was presented with a silver loving cup by the interns and physicians of the hospital in appreciation of his services. Dr. Gelpi will resume his duties immediately.

Dr. A. Parker Hitchens, one of the noted bacteriologists in the United States, has accepted an appointment as associate director of the biological division of the Lilly laboratories.

Dr. William H. Harris, 1201 Maison Blanche Building, announces the association with him of Dr. Andrew V. Friedrichs in pathology and bacteriology.

MARRIED.—On March 19, 1919, Dr. William Barclay Terhune, of New Orleans, to Miss Jane Denham, of Rayville, La.

PUBLICATIONS RECEIVED

P. BLAKISTON'S SON & CO., Philadelphia, 1919.

Beverages and Their Adulteraton, by Harvey W. Wiley, M. D.

An International System of Ophthalmic Practice. Edited by Walter L. Pyle, A. M., M. D. **Medical Ophthalmology,** by Arnold Knapp, M. D.

The Diagnostic Treatment of Tropical Diseases, by E. R. Stitt, A. B., Ph. G., M. D., LL. D. Third edition, revised.

W. B. SAUNDERS COMPANY, Philadelphia and London, 1919.

Complete Index to Volumes I, II and III of Warbasse's Surgical Treatment.

The Medical Clinics of North America. November, 1918. Vol. 2, No. 3. Philadelphia Number.

Surgcal Treatment, by James Peter Warbasse, M. D. In three volumes. Vol. III.

C. V. MOSBY COMPANY, St. Louis, 1918.

Rœntgenotherapy, by Albert Franklin Tyler, B. Sc., M. D.

GOVERNMENT PRINTING OFFICE, Washington, D. C., 1919.

Public Health Reports. Vol. 34, Nos. 5, 6, 7, 8 and 9.

MISCELLANEOUS:

Report of the Philippines Health Service. From January 1 to December 31, 1917. (Manila Bureau of Printing, 1918.)

Annual Report of the Library of the College of Physicians of Philadelphia. For the year 1918.

REPRINTS.

Early Diagnosis of Cerebrospinal Meningitis by the Examination of Stained Blood Films. Report of Cases, by Dr. W. W. King.

Epidemc Influenza, 1918, by J. C. Bhatt and K. M. Hiranandani.

LAST NOTICE.

Remember the date of the meeting of the Louisiana State Medical Society, April 8, 9, and 10.

Prepare to come.

MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for February, 1919.

CAUSE.	White.	Colored.	Total.
Typhoid Fever	2	------	2
Intermittent Fever (Malarial Cachexia)	------	------	------
Smallpox	------	------	------
Measles	------	------	------
Scarlet Fever	------	------	------
Whooping Cough	1	------	1
Diphtheria and Croup	1	------	1
Influenza	64	39	103
Cholera Nostras	------	------	------
Pyemia and Septicemia	------	------	------
Tuberculosis	55	40	95
Cancer	30	9	39
Rheumatism and Gout	1	3	4
Diabetes	4	1	5
Alcoholism	------	------	------
Encephalitis and Meningitis	------	------	------
Locomotor Ataxia	------	------	------
Congestion, Hemorrhage and Softening of Brain	25	15	40
Paralysis	1	1	2
Convulsions of Infancy	1	------	1
Other Diseases of Infancy	12	6	18
Tetanus	1	2	3
Other Nervous Diseases	8	2	10
Heart Diseases	76	41	117
Bronchitis	5	3	8
Pneumonia and Broncho-Pneumonia	56	35	91
Other Respiratory Diseases	4	------	4
Ulcer of Stomach	------	------	------
Other Diseases of the Stomach	1	1	2
Diarrhea, Dysentery and Enteritis	4	3	7
Hernia, Intestinal Obstruction	5	2	7
Cirrhosis of Liver	3	3	6
Other Diseases of the Liver	4	------	4
Simple Peritonitis	------	------	------
Appendicitis	4	4	8
Bright's Disease	20	14	34
Other Genito-Urinary Diseases	15	9	24
Puerperal Diseases	2	1	3
Senile Debility	6	1	7
Suicide	1	1	2
Injuries	15	16	31
All Other Causes	23	15	58
TOTAL	450	267	679

Still-born Children—White, 18; colored, 19; total, 37.

Population of City (estimated)—White, 283,000; colored, 106,000; total, 388,000.

Death Rate per 1,000 per Annum for Month—White, 19.08; colored, 30.23; total, 22.12. Non-residents excluded, 19.09.

METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmospheric pressure..... 30.01
Mean temperature..... 37
Total precipitation..... 6.52 inches
Prevailing direction of wind, southwest.